SO OTHERS MIGHT EAT

71 O Street, N.W.
Washington, DC 20001-1290
(202) 797-8806
FAX (202) 265-3849

Statement of Maurice Wright, Medical Director, So Others Might Eat Health Services
Committee on Government Reform Briefing on
Implementation of the Medicare Drug Benefit
January 20, 2006

Good Morning and thank you Congressman Waxman and other members of this congressional committee for this opportunity to outline some of the problems which we have experienced with Medicare Part D.

My name is Dr. Maurice Wright. I am the Medical Director/Staff Internist at So Others Might Eat Health Services in DC. We are a part of our parent organization, So Others Might Eat, Inc (S. O. M. E.). S. O. M. E. is an interfaith community-based organization that exists to help the poor and homeless of our nation's capital.

The Health Services Division provides fulltime dental, mental health, drug rehab and primary care services to DC's neediest residents. Last year, we provided primary care services to approximately 1100 patients during 6600 visits. Approximately 150 of our clients are Medicare beneficiaries(with 2/3 being classified as dual eligibles possessing both Medicare and Medicaid and the remaining 1/3 being sole Medicare beneficiaries). The medical staff at So Others Might Eat has encountered obstacles prior to and after the Part D's inception which have prevented our clients from obtaining full access to their prescribed medicines.

First, there has been a real problem for both providers and patients in getting specific and accurate information about how the program works. Prior to Part D's inception, there was very little specific information sent to Medicare providers which would have armed us with the necessary tools to adequately assist our Medicare patients in selecting an appropriate drug plan when they solicited our help or advice. In order for us as providers to gain a basic understanding of the general tenets of the Part D plan, we had to spend a disproportionate amount of time surfing the medicare.gov website, surfing individual drug plan websites, and waiting on the telephone to direct questions to either Medicare or private drug plan specialists or drug authorization officers. (Eg., we have experienced average wait times per phone calls to either Medicare or the private drug plans of at least an hour per call. At times we can't even get through to the drug plans and are disconnected automatically).

The printed materials sent from The Center for Medicare and Medicaid Services to beneficiaries did not always have reliable contact phone numbers for the individual drug plans. Our clients were thus unable to get answers to specific questions that they had about Part D plans. Accessing the online supplemental information from Medicare and the drug plans requires a high level of familiarity with medical terminology and internet web-browsing skills. Eg., when typing in "insulin" into the medication finder tool on the medicare.gov website, nothing comes up. The specific type of insulin has to be typed-in.

Beginning January 1, 2006, providers were promised that our most vulnerable dual beneficiary population would be guaranteed a smooth transition into the Part D program. They would be assigned to a prescription drug plan and would have no problems obtaining their medications. This unfortunately did not happen.

Firstly, there was not a clear communication from Medicare to Medicare providers as to how the neediest patients would be assigned to a plan. Eg., would cost to the beneficiary be the sole criterion for selection of the plan? Was a full faith effort made to assign a beneficiary to a plan which covered the highest percentage of his/her existing prescriptions? Some of these clients had to change plans because the plans that they were originally assigned to didn't cover the majority of their medications.

Secondly, some of these patients reported prohibitive increases in their medication co-pays which prevented them from getting medicines. It used to be that these dual eligibles only had a co-pay of $1 per medication. Now that co-pay can be as high as $5. Eg., there is one dual beneficiary patient whose co-pay went from being under $10 to over $50 for a month's worth of medication.

Finally, the sole Medicare beneficiaries have reported to us that they have not been able to fully realize the benefits of the Part D program. Unlike the dual eligibles, the sole Medicare beneficiaries have to select a plan themselves. Currently, a rate limiting step to enrollment encountered by these patients involves determining exactly how much premium and medication co-pay assistance they will get from the government.

These patients have voiced that they will not be able to afford the current co-pays/premiums without the "extra-help" subsidy that they were promised. To date, there has not been a clearly publicized directive in DC to Medicare providers which outlines the necessary steps that both a provider and patient must complete before the beneficiary can pursue the "extra-help" evaluation. These sole beneficiaries thus currently occupy an awful limbo status. Prior to Part D, they did not have health insurance which provided prescription drug coverage. They were mainly reliant upon donated medicines available either at our clinic or through indigent medication programs sponsored by pharmaceutical companies. Unfortunately, with the advent of Medicare Part D, most pharmaceutical companies have discontinued their indigent medication programs. These patients cannot afford the current Part D plans without a subsidy in premiums and co-pays. Eg., I have a 70 year old patient with advanced prostate cancer who was receiving his cancer fighting medication through a pharmaceutical company's indigent program. This program has been discontinued. We are hoping to expedite his "extra help evaluation" so that he will not have to undergo a lapse in therapy which could result in his premature death.